BEAUTIFUL FACES
VU HO, MD COSMETIC SURGERY MEDSPA

MEDICAL HISTORY AND SKINCARE ASSESSMENT

-MEDICAL HISTORY-

**** Please inform us of any change in your medical history and/or medications****

Please list all past and present health conditions: _____

Are you presently under the care of a physician for any reason? □ Yes □ No

If so, why? _____

Do you have *any* allergies? □ Yes □ No

If yes, list ***ALL*** allergies: _____

Do you have: □ Diabetes □ Cancer □ Epilepsy □ A Pacemaker □ Bleeding Disorder

Have you ever had extensive bleeding which required special treatment? □ Yes □ No

Have you ever had a heart attack? □ Yes □ No

Are you currently undergoing radiation therapy/chemotherapy for cancer? □ Yes □ No

Have you had a history of a connective tissue disorder? □ Yes □ No

Do you have severe emphysema or any condition that is oxygen-dependent? □ Yes □ No

Are you on a special diet? □ Yes □ No

Do you currently smoke? □ Yes □ No

Are you pregnant or lactating? □ Yes □ No

Are you trying to get pregnant? □ Yes □ No

Have you *ever* taken an oral retinoid (Accutane)? □ Yes □ No

If yes, date discontinued: _____

Have you *ever* had a "Cold Sore"? □ Yes □ No

If yes, when was your last cold sore? _____

Do you use ***any*** topical medications on your skin? □ Yes □ No

(Include Retin-A®, Hydroquinone, Benzoyl Peroxide, Antibiotics, Metrogel®, Efudex®, Cortisone, etc.)

List ***ALL*** *topical* medications: _____

_____

List **ALL** medications you are currently taking: (include: OTC supplements, vitamins, oral hormones, birth control pills, antibiotics, tranquilizers, diuretics, hypertension, etc.) _____

_____

List your Surgical History:_____

_____

TURN OVER

PLEASE RESPOND TO THE FOLLOWING MEDICAL CONDITIONS

****Personal and/or immediate family history****

Abnormal Scarring:	□ Y	□ N	□ F	Heart Surgery:	□ Y	□ N	□ F
Angina/Chest Pain with Exercise:	□ Y	□ N		Hemophilia	□ Y	□ N	□ F
Angioplasty:	□ Y	□ N		Hepatitis:	□ Y	□ N	□ F
Aortic Aneurysm:	□ Y	□ N	□ F	High Blood Pressure:	□ Y	□ N	□ F
Artificial Heart Valve:	□ Y	□ N		HIV/AIDS:	□ Y	□ N	
Asthma:	□ Y	□ N	□ F	Kidney Insufficiency:	□ Y	□ N	
Bleeding Disorder:	□ Y	□ N		Leukemia:	□ Y	□ N	□ F
Blood Transfusion:	□ Y	□ N		Limited Neck Mobility:	□ Y	□ N	
Cancer:	□ Y	□ N	□ F	Liver Insufficiency/Cirrhosis:	□ Y	□ N	□ F
Cortisone Medication:	□ Y	□ N		Nervous Disorder:	□ Y	□ N	□ F
Cosmetic Surgery:	□ Y	□ N		Psychiatric Treatment:	□ Y	□ N	□ F
Diabetes:	□ Y	□ N	□ F	Reaction to Lidocaine/Latex:	□ Y	□ N	
Dizziness/Fainting:	□ Y	□ N		Rheumatic Fever:	□ Y	□ N	□ F
Drug Addiction:	□ Y	□ N		Rheumatism:	□ Y	□ N	□ F
Emphysema:	□ Y	□ N		Severe Dry Eyes:	□ Y	□ N	
Epilepsy:	□ Y	□ N	□ F	Shortness of Breath:	□ Y	□ N	
Genital Herpes:	□ Y	□ N		Sinus Trouble:	□ Y	□ N	
Glaucoma:	□ Y	□ N	□ F	Stroke:	□ Y	□ N	□ F
Hay Fever:	□ Y	□ N		Tuberculosis:	□ Y	□ N	□ F
Heart Attack:	□ Y	□ N	□ F	Thyroid Disease:	□ Y	□ N	□ F
Heart Catherization/Stress Test	□ Y	□ N		Venereal Disease:	□ Y	□ N	
Date: _____							
□ Normal □ Abnormal				Are you currently taking	□ Y	□ N	
Heart Disease/Failure:	□ Y	□ N	□ F	Coumadin, Plavix or Aspirin			
Heart Murmur:	□ Y	□ N	□ F	on a doctor's orders:			
Heart Pacemaker:	□ Y	□ N	□ F				

Is there anything else that you would like Dr. Ho to know about you?

_____

Medical Exclusions: _____

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SKIN ASSESSMENT AND HISTORY

Has your skin been aggressively exfoliated in the last 2 weeks? □ Yes □ No

If so, please explain type(s) of exfoliation: _____

Please respond if you have had the following procedures:

Microdermabrasion:	□ Yes	□ No	Procedure/Date: _____
Chemical Peel(s):	□ Yes	□ No	Procedure(s)/Date: _____
Laser Resurfacing:	□ Yes	□ No	Procedure(s)/Date: _____
Photofacial/IPL:	□ Yes	□ No	Procedure(s)/Date: _____
Facial Surgery:	□ Yes	□ No	Procedure(s)/Date: _____
Botox/Dysport:	□ Yes	□ No	Procedure(s)/Date: _____
Fillers (Restylane, Juvederm, Perlane, Radiesse):	□ Yes	□ No	Procedure(s)/Date: _____

Acne or periodic breakouts:	□ Yes	□ No	
If so, please mark frequency:	□ Monthly	□ Always	□ Rarely
Oily Skin throughout the day:	□ Yes	□ No	□ Occasionally
Does your skin have a tendency to redness?	□ Yes	□ No	□ Occasionally
Does your skin ever flake or feel tight/dry?	□ Yes	□ No	□ Occasionally

During pregnancy, did you develop pigmentation or "masking?"	□ Yes	□ No	□ N/A
Are you presently going through menopause?	□ Yes	□ No	
Do you ever use tanning beds?	□ Yes	□ No	
Do you wear a sun protection product **all day every day**?	□ Yes	□ No	

How do you tan? □ Always Burn □ Usually Burn □ Sometimes Burn
□ Rarely Burn □ Never Burn

What is your ethnic origin? □ African American □ Asian □ Caucasian
□ Hispanic □ Middle Eastern □ Native American
□ Other: _____

What skin care products do you currently use? □ Cleanser □ Exfoliator □ Serum(s)
□Retinol □ Moisturizer □ Eye Product □ SPF
□ Other: _____

What is your primary skin concern? _____

I confirm, to the best of my knowledge, that the answers I have given are correct and that I have not withheld any information that may be relevant to my treatment.

Patient Signature: _____ Date: _____

Provider Signature: _____ Date: _____